

FILED MAR 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6879

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1777	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Overland St. Louis 4221			
d. FULL NAME OF HOSPITAL OR INSTITUTION Enroute to City Hospital				d. STREET ADDRESS (If rural, give location) 9244 Maribel Ave. Overland, Mo.			
3. NAME OF DECEASED (Type or Print) a. (First) Allie		b. (Middle) _____		c. (Last) West		4. DATE OF DEATH (Month) (Day) (Year) Feb. 21, 1950	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 9, 1899	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) Russellville, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Kelly West		13b. MOTHER'S MAIDEN NAME Jane Rowark		14. NAME OF HUSBAND OR WIFE Mae West - 9414 Maribel Ave.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mae West 9414-Maribel Ave-Overland Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:41 A. M., from the causes and on the date stated above.						23. SIGNATURE Patrick E. Taylor, M.D. (Degree or title)	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/24/50		24c. NAME OF CEMETERY OR CREMATORY Free Free Cemetery		24d. LOCATION (City, town, or county) (State) Pattonville, Mo.	
DATE REC'D BY LOCAL REG. 2/23/50		REGISTRAR'S SIGNATURE J. B. Jasson		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Baumann Brothers Inc 2504-Woodson Rd.-Overland-14-Mo.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by_____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Osborn J. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 14 Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.